1990 cost report. In subsequent years, but no more often than every second year, the office will use the most recent cost report data to determine a cost per resident per day that more accurately reflects the cost of efficiently providing hospital services as it relates to operating a medical education program. The number of residents will be determined according to the most recent available cost report filed on or before April 1 of the current fiscal year. In the absence of rebasing, the medical education per diem will be inflated annually using the Hospital Market Basket Index published in the second quarter of the current year.

For hospitals establishing new medical education programs, the medical education per diem will be effective no earlier than two (2) months prior to notification to the office that the program has been implemented. The medical education per diem shall be based on the most recent reliable claims data and cost report data.

Medical education payments will be available to hospitals only so long as they continue to operate medical education programs. Hospitals that discontinue medical education programs must promptly notify the office of that fact.

Cost Outlier

A Medicaid stay that exceeds a predetermined threshold, defined as the greater of: (1) twice the DRG rate or (2) $25,000, is a cost outlier case. The calculation for outlier payment amounts is made as follows:

(1) The prospective determination of costs per inpatient stay shall be calculated by multiplying a cost-to-charge ratio (calculated using FY 90 settled cost reports) by submitted charges.

(2) The outlier payment shall be equal to 60 percent of the difference between the prospective cost per stay, and the outlier threshold amount.

(3) Day outliers as required under Section 1902(s) of the Social Security act are provided for through implementation of the DRG/LOC per diem, which is designed to account for unpredictable and lengthy hospital admissions.

Outlier thresholds will be revised as necessary when DRG relative weights are adjusted.

Payment Policy for Readmission

Readmissions will be treated as separate stays for payment purposes but will be subject to medical review. If it is determined that a discharge is premature, payments made as a result of the discharge/readmission may be subject to recoupment.

Transfer Policies

Transfer cases have special payment policies.

* The transferee hospital (hospital that accepts a transfer from another hospital) is paid according to the DRG or level-of-care methodology.

* The transferring hospital (hospital that initially admits then discharges the patient to another hospital) is paid the sum of the following:

If the case groups, and is to be paid under the DRG methodology:

(a) A DRG rate for each Medicaid day of the recipient's stay, not to exceed the full DRG payment, plus,

(b) The capital per diem rate for each Medicaid day of the recipient's stay (the number of days of capital add-on payments paid, not to exceed the average length of stay for the DRG that the case grouped in) plus,

(c) The medical education per diem rate (if applicable) for each Medicaid day of the recipient's stay (the number of days of medical education add-on payments paid, not to exceed the average length of stay for the DRG that the case grouped in). **NOTE: MEDICAL EDUCATION PER DIEM PAYMENTS ARE AVAILABLE ONLY TO THOSE HOSPITALS THAT QUALIFY FOR MEDICAL EDUCATION PAYMENTS AS DEFINED ELSEWHERE IN THIS PLAN.**

If the case is to be paid under the LOC methodology:

(a) The LOC per diem rate for each Medicaid day of care provided plus,

(b) The capital per diem rate for each Medicaid day of the recipient's stay plus,

(c) The medical education per diem rate (if applicable) for each Medicaid day of the recipient's stay. **NOTE: MEDICAL EDUCATION PER DIEM RATE PAYMENTS ARE AVAILABLE ONLY TO THOSE HOSPITALS THAT QUALIFY FOR MEDICAL EDUCATION PAYMENTS AS DEFINED ELSEWHERE IN THIS PLAN.**

Certain DRGs are established to specifically include only transfer cases; for these DRGs, reimbursement shall be equal to the DRG rate.

Reimbursement For Less Than One-day Stays

Special payment policies shall apply to less than one-day stays that are paid according to a DRG rate. For less than one-day stays, hospitals will be paid a DRG daily rate, the capital per diem rate for one (1) day of stay, and the medical education per diem rate (if applicable) for one (1) day of stay.

Reimbursement for New Providers and Out-of-State Providers

Payment rates for inpatient services in inpatient hospital facilities that commenced participation in the State Medicaid program after fiscal year 1990 and for out-of-state hospitals participating in the Indiana Medicaid program shall be the sum of the components in the DRG or LOC methodologies as follows:

- The DRG rate that would be paid to in-state providers for cases that group into appropriate DRGs, computed in accordance with the DRG section of this plan, plus a statewide median capital rate computed in accordance with the CAPITAL PAYMENT section of this plan, plus a hospital-specific medical education rate (if applicable) computed in accordance with the MEDICAL EDUCATION section of this plan and if applicable, an outlier payment computed in accordance with the OUTLIER section of this plan. For purposes of estimating costs, the statewide median cost-to-charge ratio (calculated from FY 1990 settled cost reports) will be used.

* The Level of Care rate that would be paid to in-state providers for cases that are paid using the Level of Care methodology computed in accordance with the LOC sections of this plan. The LOC payment shall be made for certain burn cases, acute care psychiatric and rehabilitation cases. The rate of payment shall be the in-state psychiatric rate, the burn/2 rate (or if applicable, the burn/1 rate), or the rehabilitation LOC rate, plus the statewide median capital rate computed in accordance with the CAPITAL PAYMENT section of this plan, plus a hospital-specific medical education rate (if applicable) and if applicable, an outlier payment computed in accordance with the OUTLIER section of this plan. For purposes of estimating costs, the statewide median cost-to-charge ratio (calculated from FY 1990 settled cost reports will be used.

DEFINITIONS

"Allowable costs" means Medicare allowable costs as defined by 42 USC 1395(f)

"All patient DRG grouper" refers to a classification system used to assign inpatient stays to DRGs.

"Base amount" means the rate per Medicaid stay which is multiplied by the relative weight to determine the DRG rate.

"Base period" means the fiscal years used for calculation of the prospective payment rates including base amounts and relative weights.

"Capital costs" are costs associated with the ownership of capital and include depreciation, interest, property taxes and property insurance.

"Children's hospital" means an inpatient hospital facility (general acute care hospital properly licensed under Indiana Code) whose primary specialty is providing short term acute care medical services for children and newborns.

"Cost outlier case" means a Medicaid stay that exceeds a predetermined threshold defined as the greater of twice the DRG rate or a fixed dollar amount established by the office. The initial fixed dollar amount for the threshold is twenty-five thousand dollars ($25,000). This amount may be changed at the time DRG relative weights are adjusted.

"Diagnosis-related group" or "DRG" means a classification of an inpatient stay according to the principal diagnosis, procedures performed, and other factors that reflect clinically cohesive groupings of inpatient hospital stays utilizing similar resources. Classification is made through the use of the all patient (AP) DRG grouper.

"Direct medical education costs" means the costs that are associated with the salaries and benefits of medical interns and residents and paramedical education programs.

"Discharge" means the release of a patient from an acute care facility. Patients may be discharged to their home, another health care facility, or due to death. Transfers from one (1) unit in a hospital to another unit in the same hospital shall not be considered a discharge, unless one (1) of the units is paid according to the level-of-care approach.

"DRG daily rate, means the per diem payment amount for a stay classified into a DRG calculated by dividing the DRG rate by the average length of stay for all stays classified into the DRG.

"DRG rate" means the product of the relative weight multiplied by the base amount. It is the amount paid to reimburse hospitals for routine and ancillary costs of providing care for an inpatient stay.

"Hospital Market Basket Index" or "Market Basket Index" or "Index" means the DRI-Type Hospital Market Basket Index, published quarterly by DRI/McGraw Hill in "Health Care Costs".

"Inpatient" means a Medicaid patient who was admitted to a medical facility on the recommendation of a physician and who received room, board, and professional services in the facility.

"Inpatient hospital facility" means a general acute care hospital, a mental health institution, a state mental health institution or a rehabilitation inpatient facility properly licensed as a hospital in accordance with appropriate Indiana Code.

"Less than one-day stay" means a medical stay of less than twenty-four (24) hours that is paid according to a DRG rate.

"Level-of-care case" means a medical stay, that is not part of the DRG reimbursement system. Level-of-care cases include psychiatric cases, rehabilitation cases and certain burn cases.

"Level-of-care rate" means a per diem rate that is paid for treatment of a diagnosis or performing a procedure that is not paid through the DRG reimbursement system.

"Medicaid day" means any part of a day, including the date of admission, for which a patient enrolled with the Indiana Medicaid program is admitted as an inpatient and remains overnight. The day of discharge is not considered a Medicaid day.

"Medicaid stay" means an episode of care provided in an inpatient setting that includes at least one (1) night in the hospital and is covered by the Indiana Medicaid program.

"Office" means the Office of Medicaid Policy and Planning of the Indiana Family and Social Services Administration.

"Outlier payment amount" means the amount reimbursed in addition to the DRG rate for certain inpatient stays that exceed cost thresholds established by the office.

"Per diem" means an all-inclusive rate per day.

"Principal diagnosis" means the diagnosis, as described by ICD-9-CM code, for the condition established after study to be chiefly responsible for occasioning the admission of the patient for care.

"Readmission" means that a patient is admitted into the hospital within fifteen (15) days following a previous hospital admission and discharge for a related condition as defined by the office.

"Rebasing" means the process of adjusting the base amount relying upon the most recent reliable claims data, cost report data, and other information relevant to hospital reimbursement.

"Relative weight" means a numeric value which reflects the relative resource consumption for the DRG to which it is assigned. Each relative weight is multiplied by the base amount to determine the DRG rate.

"Routine and ancillary costs" means costs that are incurred in providing services exclusive of medical education and capital costs.

"Transfer" means a situation in which a patient is admitted to one (1) hospital and is then released to another hospital during the same episode of care. Movement of a patient from one (1) unit within the same hospital will not constitute a transfer unless one (1) of the units is paid under the level-of-care reimbursement system.

"Transferee hospital" means the hospital that accepts a transfer from another hospital.

"Transferring hospital" means the hospital that initially admits then discharges the patient to another hospital.

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

I. AUTHORITY

In compliance with Section 1902 (a)(13)(A) of the Act, Section 1923 of the Act, and specifically the mandates of section 4112 (OBRA 1987), P.L. 100-203, the Indiana Medicaid program adopts the following definitions and methodologies to identify and make payments to hospitals to take into account the situation of such providers that serve a disproportionate number of low-income patients with special needs.

II. DEFINITIONS

(A) "Acute Care Hospital" has the following meaning: "Any institution, place, building, or agency represented and held out to the general public as ready, willing, and able to furnish care, accommodations, facilities, and equipment, for the use, in connection with the services of a physician, of persons who may be suffering from deformity, injury, or disease, or from any other condition, from which medical or surgical services would be appropriate for care, diagnosis, or treatment." The term does not include a state mental health institution or a private psychiatric institution, nor does it include convalescent homes, boarding homes, homes for the aged or freestanding health facilities licensed for long term care such as nursing facilities.

(B) "State Mental Health Institution" has the following meaning: "A state-owned or state-operated institution for the observation, care, treatment, or detention of an individual; and under the administrative control of the division of mental health." This group of providers is commonly referred to as state hospitals.

(C) "Private Psychiatric Institution" has the following meaning: "An acute care inpatient facility, properly licensed for the treatment of persons with mental illness." This group of providers is commonly referred to as private psychiatric hospitals.

(D) "Community Mental Health Center" has the following meaning: "a program of services approved by the division of mental health and organized for the purpose of providing multiple services for the mentally handicapped and operated by one of the following or combinations thereof:

(1) Any city, town, county or other political subdivision of this state; any agency of the state of Indiana or of the United States; and any political subdivision of another state; including but not limited to and without limiting the generality of the foregoing, hospitals owned or operated by units of government and building authorities organized for the purpose of constructing facilities to be leased to units of government;

(2) A corporation incorporated under the provisions of IC 1971, 23-7-1.1, the "Indiana General Not for Profit Corporation Act";

(3) A nonprofit corporation incorporated in another state; and (4) A university or college."

(E) "Basic Disproportionate Share Hospital" has the following meaning: An Acute Care Hospital, State Mental Health Institution, Private Psychiatric Institution, or Community Mental Health Center that qualifies as an inpatient hospital eligible for DSH payments as set out in the requirements in section 1923 of the Act,

(1) whose Medicaid Inpatient Utilization Rate is at least one standard deviation above the Statewide Mean Medicaid Inpatient Utilization Rate for such provider hospitals receiving Medicaid payments in Indiana, or,

(2) whose low income utilization rate exceeds twenty-five percent (25%).

No hospital may be a basic disproportionate share hospital unless the hospital:

(I) has a Medicaid utilization rate of at least one percent (1%); and

(ii) has at least two (2) obstetricians with staff privileges, who have agreed to provide obstetric services to individuals entitled to such services under the Indiana Medicaid state plan. For a hospital located in a rural area (as defined in Section 1886 of the Social Security Act), the term obstetrician includes a physician with staff privileges at the hospital to perform non emergency obstetric procedures. This provision, (ii), does not apply to a hospital the inpatients of which are predominately individuals under 18 years of age; or which did not offer non-emergency obstetric services as of December 21, 1987.

For state fiscal years ending after June 30, 1997, each hospital's eligibility for basic disproportionate share payments under this section shall be based on utilization and revenue data from the most recent year for which an audited cost report for the individual hospital is on file with the office.

(F) "Enhanced Disproportionate Share Hospital" has the following meaning: An acute care hospital licensed by the State of Indiana that, based on utilization and revenue data from the most recent year for which an audited cost report from the provider is on file with the office,

(1) has a Medicaid Inpatient Utilization Rate at least one standard deviation above the Statewide Mean Medicaid Inpatient Utilization Rate for such provider hospitals receiving Medicaid payments in Indiana; or

(2) has a low income utilization rate exceeding twenty-five percent (25%).

No hospital may be an enhanced disproportionate share hospital unless the hospital:

(i) has at least two (2) obstetricians with staff privileges, who have agreed to provide obstetric services to individuals entitled to such services under the Indiana Medicaid state plan. For a hospital located in a rural area (as defined in Section 1886 of the Social Security Act), the term obstetrician includes a physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This provision, (I), does not apply to a hospital the inpatients of which are predominately individuals under 18 years of age; or which did not offer non emergency obstetric services as of December 21, 1987; and

(ii) has a Medicaid utilization rate of at least one percent (1%).

(G) "Municipal Disproportionate Share Provider" has the following meaning: An acute care hospital licensed by the State of Indiana and established and operated under Indiana Code 16-22-2 or 16-23, that based on utilization and revenue data from the most recent year for which an audited cost report is on file with the office, has a Medicaid Inpatient Utilization Rate greater than one percent (1%). IC 16-22-2 and IC 16-23 are the enabling statutes for county and city-county hospitals under Indiana law.

(H) "Community Mental Health Center Disproportionate Share Provider" has the following meaning: An entity designated as a community mental health center by the state division of mental health, that receives funding under Indiana Code 12-29-1-7(b) or from other county sources, that provides inpatient services to Medicaid patients, and whose Medicaid Inpatient Utilization Rate, based on utilization and revenue data from the most recent year for which an audited cost report is on file with the office, is greater than one percent (1%). Indiana Code 12-29-1-7(b) provides for property tax funding by individual counties of community mental health centers situated in those counties.

(I) "Medicaid Inpatient Utilization Rate" for a provider, has the following meaning: A fraction (expressed as a percentage) for which:

(1) the numerator is the provider's total Medicaid inpatient days in the most recent year for which an audited cost report is on file with the office; and

(2) the denominator is the total number of the provider's inpatient days in that same cost reporting period, where inpatient days includes each day in which an individual (including newborns, Medicaid managed care beneficiaries, and Medicaid beneficiaries from other states) is an inpatient in the hospital, whether or not the individual is in a specialized ward (including acute care excluded unit distinct part subproviders of the provider) and whether or not the individual remains in the hospital for lack of suitable placement elsewhere. The term "inpatient days" includes days attributable to individuals eligible for

Attachment 4.19 A
Page 4a

Frank O'Bannon, Governor
State of Indiana

Office of Medicaid Policy and Planning
402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

Venita J. Moore, Acting Secretary

INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION
FSSA
"People helping people help themselves"

May 7, 1999

Ms. Jean Hall, HCFA
Health Insurance Specialist
Division of Medical and State Administration
HCFA Region V
105 West Adams Street
15th Floor
Chicago, IL 60603-6201

Dear Ms. Hall:

Per our conversation on Monday, May 3, 1999, below please find the suggested language that would revise section (H) on page 4 of Attachment 4.19A of the pending SPA TN #98-011:

The passage in the pending DSH SPA TN #98-011 specifically reads:

"(H) "Community Mental Health Center Disproportionate Share Provider" has the following meaning: **An entity** designated as a community mental health center by the state division of mental health, that receives funding under Indiana Code 12-29-1-7(b) or from other county sources, that provides inpatient services to Medicaid patients . . . "

The suggested language to revise section (H) is:

(H) "Community Mental Health Center Disproportionate Share Provider" has the following meaning: **A community mental health center designated as such** by the state division of mental health, that receives funding under Indiana Code 12-29-1-7(b) or from other county sources, that provides inpatient services to Medicaid patients . . . "

If you have any questions, please do not hesitate to contact me 317-233-1553.

Sincerely,

William Washienko
Policy Analyst

HCFA-179 # 98-011 Date Rec'd 6/30/98
Supercedes NEW Date Appr. MAY 11 1999
State Rep. In JH Date Eff. 4/1/98

Medicaid in Indiana or any other state. The term does not include days attributable to Medicaid patients between the ages of 21 and 65 in Institutions for Mental Disease.

(J) "Statewide Mean Medicaid Inpatient Utilization Rate" has the following meaning: A fraction (expressed as a percentage) for which:

(1) the numerator is the total of all Medicaid enrolled hospital providers' Medicaid Inpatient Utilization Rates in the most recent year for which audited cost reports are on file with the office; and

(2) the denominator is the total number of all such Medicaid enrolled provider hospitals.

In calculating the Statewide Mean Medicaid Inpatient Utilization Rate, the Medicaid agency shall not include in the statistical database for the statewide mean calculation, the Medicaid Inpatient Utilization Rates of providers whose low income utilization rates exceed twenty-five percent (25%).

(K) A provider's "Low Income Utilization Rate" is the sum of:

(1) a fraction (expressed as a percentage) for which:

(A) the numerator is the sum of the following:

(i) the total Medicaid patient revenues paid to the provider during the most recent year for which an audited cost report is on file with the office; plus

(ii) the amount of the cash subsidies received directly from state and local governments, during the most recent year for which an audited cost report is on file with the office, including payments made under the hospital care for the indigent program; and

(B) the denominator is the total amount of the provider's revenues for patient services (including cash subsidies) during the most recent year for which an audited cost report is on file with the office; and

(2) a fraction (expressed as a percentage) for which:

(A) the numerator is the total amount of the provider's charges for inpatient services during the most recent year for which an audited cost report is on file with the office that are attributable to care provided to individuals who have no source of payment or third party or personal resources, less the amount of any cash subsidies described in clause (K)(1)(A)(ii) above; and